emailed validation letter 10/1/10

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 8-30-10
Amount $300 -
Ch# 30455

RECEIVED
AUG 30 2010
OFFICE OF INSPECTOR GENERAL

I. IDENTIFICATION

Name: Shemwell Health Care
Address: 805 Princeton Rd
City/County/Zip: Providence Ky 42450
Telephone number: 270 667 5472
Administrator: Billie Cole RN
Date facility operation began at current address: 1960
Date facility began operation under current owner: 1974

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home	20	20
Nursing Facility		
Intermediate Care	~~2~~	~~2~~
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State
County
City
Private ✓

Profit ✓
Nonprofit

Individual
Partnership ✓
Corporation

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Wayne & Billie Cole 121 E. Main St. Providence Ky

Tommy & Benita Chandler 218 Benjamin Terrace Providence Ky

(OVER)

9/30

If facility owned or leased by a corporation, complete the following:

Name of corporation _____

Address of corporation _____

President or Chairman _____

Vice President _____

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Shirley Hamer
Signature of authorized representative

RN DON
Title

8/27/10
Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)